Child Fatalities, 2010-2011

Statistics, Analyses, and Recommendations

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Introduction

The Child and Family Services Agency (CFSA) reviews and reports annually on fatalities of District children and youth in families with whom we have had contact within four years of the deaths.[1] These annual reports are based on internal inquiries that we conduct for every fatality that meets our criteria for review and findings and recommendations we gain from those reviews.

The fatality review process is one of CFSA's most important vehicles for strengthening child welfare performance. It provides specific information that helps to correct deficiencies and to identify any systemic factors that require agency- or city-wide attention. *Child Fatalities, 2010-2011* also provides insights into how CFSA works to ensure the safety of children in District custody.

This seventh report includes statistics, analyses, and recommendations related to children and youth who died during the calendar years of 2010 and 2011, and who had contact with CFSA within five years of their death. For purposes of this report, the term "contact" includes:

- cases that were current and active at the time of death,
- cases that were active within four years before the reported year of death but closed at the time of death, and
- reports to CFSA's 24-hour Child Protective Services (CPS) hotline that CPS investigated within the four-year time frame but that did not meet the criteria for opening a child welfare case.

Throughout this report, the terms "known children" and "known fatalities" refer to deaths of children and youth who fit this definition.

Methodology

The District has a two-tiered process for reviewing child fatalities. At the macro level, the DC Child Fatality Review Committee (DC CFRC), under the auspices of the DC Office of the Chief Medical Examiner (OCME), identifies broad systemic issues that influence all child fatalities in the District. Its multidisciplinary review team is composed of representatives from public and private agencies who work in the fields of education, health care, mental health, human services, jurisprudence, law enforcement, public safety, and other forms of community service. The OCME publishes annual reports of city-wide statistics and recommendations regarding child fatalities, including fatalities involving domestic violence.

At the micro level, District child-serving agencies conduct internal reviews of deaths of children known to them. CFSA's internal Child Fatality Review Team includes employees from several programs and functions and external stakeholders from child-serving and oversight organizations and the community.

To prepare this report, the Child Fatality Review Unit (CFRU) within CFSA's Quality Improvement Division analyzed information from the following sources.

- The DC CFRC and OCME provided official cause and manner of death and verified identifying information for each death.

[1] Although the designation "four years" is used in this report and in most legal documents involving our internal review, in practice we review all fatalities that occur within four years and 364 days of a family's involvement with CFSA.

- The Metropolitan Police Department (MPD) and reports from local news media were helpful in providing time and location of violent homicides.

- In addition to date and time (when available), CFSA's Child Fatality Review Unit maintains a database of basic fatality information, such as circumstances surrounding the death and demographics, and also prepares reports following internal child fatality review meetings.

- Many insights come from CFSA case records and interviews with social workers, service providers, attorneys, administrators, and others who were involved with the child or family.

Overview of CFSA's Child Fatality Review Process

Notification of Child Fatalities

Notification of a child death generally comes through CFSA's CPS hotline (202-671-SAFE), often from a law enforcement officer or social worker or other staff member who has learned of the fatality. (CFSA policy requires that any employee who receives notification of a fatality involving a current or former child client must immediately notify the hotline.) Notification about a death that has just taken place prompts CPS to ensure the safety of other children in the home and to assist the family with any immediate needs. CFSA's Child Fatality Review Unit also routinely checks local media reports of deaths of children and youth against child welfare case records, and occasionally, a veteran social worker will recognize a name from a news report. Sometimes, CFSA learns about the death of a former client long after the fact. We typically get these notifications from the OCME, which may connect the dots back to child welfare only through research into District Agency records.

Immediate First-Level Review

CFSA's CFRU convenes an internal Child Fatality Critical Event meeting within 24 hours of receiving notice of a recent child fatality.[2] Participants include, but are not limited to, representatives from CFSA's senior management team, Office of the General Counsel, CPS, In-Home and Out-of-Home Permanency Administrations, Office of Clinical and Health Services, and Quality Improvement.

While Critical Event meetings explore circumstances surrounding a child's death, the first focus is on identifying immediate needs of the family. In particular, participants assess the level of risk, if any, to other children remaining in the home. Some Critical Event meetings result in recommendations, either for immediate steps for the investigative social worker (or other currently-involved personnel) or for next steps by other staff as appropriate. It is at this meeting that Quality Improvement decides whether the fatality is appropriate for an internal fatality review.

[2] Generally, CFSA does not hold a CFCE meeting when the fatality involves a former CFSA client who is now an adult (age 21 or older) or when we learn of the death weeks or months after the fact. CFSA also does not hold a CFCE meeting for deaths of children with no previous CFSA contact.

Monthly Second-Level Review

For the internal review of each child fatality, CFRU staff prepares a written report based on a comprehensive review of information about the decedent and his or her family. Sources include the CFSA investigative and/or case record, both hard copy and electronic (from FACES, CFSA's automated case management system). Additional sources of information include the Automated Client Eligibility Determination System (ACEDS) of the DC Department of Human Services; interviews with current and past social workers, when possible; and any information available from OCME, MPD, and relevant media coverage.

These reports serve as the basis for the monthly CFSA internal Child Fatality Review meetings. We hold these meetings regularly to review fatalities within 45 days of CFSA notification of the child's death. A multidisciplinary panel of representatives from CFSA and external stakeholders reviews child welfare involvement with the child and family; identifies issues; and recommends both immediate actions and long-term strategies for improving case practice, enhancing child protection, and eliminating preventable deaths.

Focus of the Internal Child Fatality Review

1. Did parental or familial behavior factors contribute to the fatality?
2. Did CFSA take every action and make every reasonable effort to ensure the safety of the child and other children in the household?
3. Does this child fatality reveal any practice, training, or policy issues that we need to resolve?
4. Are there systemic issues such as supervision, staffing, access to records etc. that need to be addressed?
5. Knowing what we know now, what would we do differently?
6. What interagency issues should we present to the District's citywide Child Fatality Review Committee?

Overview of Child Fatality Trends

Deaths of District children declined in both 2010 and 2011, with associated drops in those known to CFSA (Table 1). Children known to CFSA as a percentage of all child deaths in the District dropped to the lowest levels in eight years.

Table 1: Eight-Year Trend in Deaths of District Children and Youth

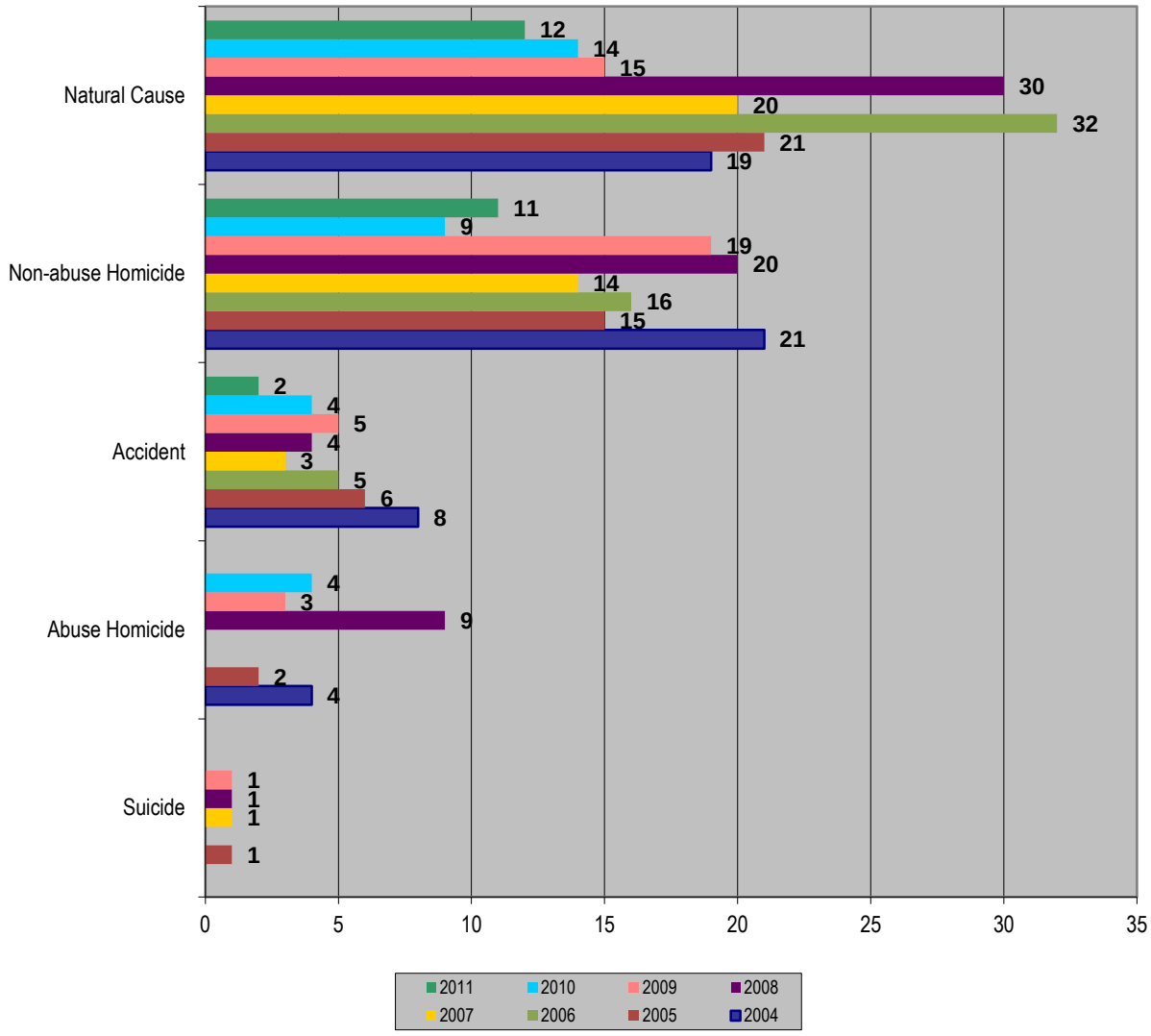
Year:	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*
Total DC child deaths	159	156	143	158	178	133	122	119
Portion known to CFSA	59 (37%)	53 (34%)	59 (41%)	44 (28%)	68 (38%)	50 (38%)	33 (27%)	26 (22%)
Number from abuse	4	2	0	0	8	4	4	0

Major causes of death of children known to CFSA remained the same, with natural causes and gunshot homicides heading the list as they have for eight years (Figure A).

'Natural' continues to be the leading cause of death for young children.

In each year under review, natural causes continued to be the leading reason why young children died—and was the leading cause of death for all children and youth known to CFSA for six of the last eight years.

Figure A: Eight-Year Trend, Five Causes of Death



Violent non-abuse homicide continues to be the leading cause of death for older youth, especially males over age 16.

For youth known to CFSA, homicide, mostly by gunshot, has been the second leading manner of death overall in six out of the last eight years and the leading cause of death for older youth for eight years running (Figure A).

Fatalities from child abuse in the District remain below the national average.

The U.S. Department of Health and Human Services' Administration for Children and Families (ACF) collects data on child fatalities due to abuse from all 50 states and the District of Columbia. For federal fiscal year 2010, child deaths from abuse occurred at a rate of 1.75 per 100,000 children in the District—

below the national average of 2.17 deaths per 100,000 children.[3] No District child died from abuse in three of the past eight years: 2006, 2007, and 2011 (Figure A).

The number of accidental deaths of children known to CFSA continues to be low.

Accidental deaths decreased from five in 2009 to four in 2010 and to two in 2011.

Males continue to die at a higher rate than females.

Of children known to CFSA, males remain at higher risk of death than females (Table 2). In 2008, the ratio of male to female deaths was almost 2:1. In 2009 and 2011, it was almost 3:1.

Table 2: Gender of Decedents Known to CFSA, 2007-2011

Year:	*2007*	*2008*	*2009*	*2010*	*2011*	*Total*
Male	26 (59%)	45 (66%)	32 (72%)	19 (58%)	19 (73%)	141 (66%)
Female	18 (41%)	23 (34%)	12 (28%)	14 (42%)	7 (27%)	74 (34%)

Analyses of Child Fatalities in 2010-2011

This section takes a closer look at specific circumstances related to the deaths in 2010 and 2011, of the 59 children and youth known to CFSA. Tables below provide overviews by year: Table 3 shows 2010, and Table 4 shows 2011.

Table 3: Manner of Death and Demographics for 33 Children Who Died in 2010 and Who Had Contact with CFSA at any Point in the Preceding Four Years

*Manner of death:**	*Natural Cause*	*Non-abuse Homicide*	*Abuse Homicide*	*Accident*	*Suicide*	*Undetermined***	*Total*
AGE							
<24 months	8	0	1	1	0	1	**11**
2-6 years	1	0	0	2	0	0	**3**
7-12 years	0	0	0	0	0	0	**0**
13-16 years	1	3	2	1	1	0	**8**
17+ years	4	6	1	0	0	0	**11**
GENDER							
Male	5	9	2	2	0	1	**19**
Female	8	0	2	2	1	1	**14**
STATUS WITH CFSA AT TIME OF DEATH							
Closed case	5	4	2	1	1	1	**14**
Active case	4	3	0	0	0	0	**7**
Closed investigation, no case opened	4	2	2	3	0	0	**11**
Active investigation	1	0	0	0	0	0	**1**
PLACEMENT LOCATION AT TIME OF DEATH							
Not applicable: case closed	9	6	4	4	1	1	**25**
In home	3	1	0	0	0	0	**4**
Out-of-home placement	2	2	0	0	0	0	**4**
Total	**14(42%)**	**9 (27%)**	**4 (12%)**	**4 (12%)**	**1(03%)**	**1 (03%)**	**33**

** Information from Medical Examiner or CFRC as of October, 2012. Final numbers provided by CFRC may differ from numbers reported earlier based on preliminary data.*
*** Medical Examiner issued an autopsy report but was unable to determine cause of death.*

[3] http://archive.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf, p.63.

Table 4: Manner of Death and Demographics for 26 Children Who Died in 2011 and Whose Family Had Contact with CFSA at any Point in the Preceding Four Years							
Manner of death:	***Natural Cause***	***Non-abuse Homicide***	***Abuse Homicide***	***Accident***	***Suicide***	***Undetermined*****	***Total***
AGE							
<24 months	8	0	0	0	0	1	**9**
2-6 years	1	0	0	1	0	0	**2**
7-12 years	0	0	0	0	0	0	**0**
13-16 years	1	1	0	0	0	0	**2**
17+ years	3	9	0	0	0	0	**13**
GENDER							
Male	8	9	0	2	0	0	**19**
Female	5	1	0	0	0	1	**7**
STATUS WITH CFSA AT TIME OF DEATH							
Closed case	2	3	0	2	0	0	**7**
Active case	2	3	0	0	0	0	**5**
Closed investigation, no case opened	6	4	0	0	0	1	**11**
Active investigation	3	0	0	0	0	0	**3**
PLACEMENT LOCATION AT TIME OF DEATH							
Not applicable: case closed	8	7	0	2	0	1	**18**
In home	5	1	0	0	0	0	**6**
Out-of-home placement	0	2	0	0	0	0	**2**
Total	**13 (50%)**	**10 (38%)**	**0**	**2 (8%)**	**0**	**1 (3%)**	**26**

For the first time in 2011, deaths of older youth, largely from gunshots, surpassed deaths of young children, largely from natural causes.

CFSA's annual fatality reports show a long-standing trend that children under age 2 and youth over age 17 are the two age groups most at risk of death. The trend of children under 2 years old (commonly thought to be the most vulnerable) having the highest number of fatalities ended in 2010, when youth age17 and older tied the number. The following year, older youth represented the largest single age group, making up half of all fatalities of children known to CFSA for the year (Table 5). These two age groups continue to dominate our statistics. Three quarters (75%) of the 59 child decedents in 2010-2011 were either younger than age 2 or older than age 16. No child between the ages of 7 and 12 died in either year.

Table 5: Eight-Year Trend, Deaths of Children and Youth Known to CFSA by Age								
Year:	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***
<24 months	20 (34%)	24 (45%)	24 (41%)	19 (43%)	26 (38%)	22 (44%)	11 (33%)	9 (35%)
2-6 years	3 (5%)	1 (2%)	2 (3%)	5 (11%)	7 (10%)	2 (4%)	2 (9%)	2 (8%)
7-12 years	8 (14%)	3 (6%)	5 (8%)	3 (7%)	6 (9%)	4 (8%)	0	0
13-16 years	11 (19%)	9 (17%)	9 (15%)	5 (11%)	8 (12%)	5 (10%)	8 (24%)	2 (8%)
17+ years	17 (29%)	16 (30%)	19 (32%)	13 (30%)	21 (31%)	17 (34%)	11 (33%)	13 (50%)

Non-Abuse Homicides, 2010-11

Violent homicide continues to claim the life of far too many District children and youth. Nine young people known to CFSA were victims of non-abuse homicide in 2010, accounting for more than a quarter of all children known to CFSA who died that year. Table 6 shows the eight-year trend that makes violent homicide a leading cause of death of young people known to CFSA. Nevertheless, as a percentage of total fatalities of children known to CFSA, violent, non-abuse homicides were lower in 2010 and 2011 than at any time in the last eight years. This mirrors the overall decline in the homicide rate in the District.

Table 6: Eight-Year Trend, Deaths of Children and Youth Known to CFSA by Violent, Non-Abuse Homicide								
Year:	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***
Total deaths from homicide	25	17	17	14	21	18	9	10
Percent of all deaths of children/youth known to CFSA	42%	32%	29%	32%	31%	36%	27%	38%

A total of 30 youth were homicide victims in the District of Columbia in 2010.[4] Of these youth, 9 (30%) were known to CFSA. All were African-American males. In 2011, nine males and one female known to CFSA were slain, for a total of 10.

A disturbing trend in 2010, was that of the nine youth known to CFSA who died from violent homicide, police believe five (56%) were targeted by their shooters or killed in acts of retaliation. One youth had just attended the funeral of a friend who was also the victim of a homicide. He was with a group that gathered outside and became the target of a drive-by shooter. Another youth was on the way to his group home after school when he was shot. The youth was reportedly targeted because he was rumored to be cooperating as a witness in a homicide investigation. In 2011, only one young adult homicide victim known to CFSA was thought to have been targeted.[5] As of December 2012, the Metropolitan Police Department website listed four of the nine homicides from 2010, and two of the 10 from 2011 as unsolved.

Several themes emerge in the tragic profiles of these 19 young victims of violent homicide. We include this information not to blame the victims but rather to identify some of the common factors that appear to place too many District young people (not just those known to the child welfare system) at risk. These factors may raise the likelihood that a young man or woman could face a dangerous situation. Knowledge of these factors should inform the city-wide discussion of how best to address the needs of vulnerable District youth and their families and may help to improve protection of those at highest risk of violence.

- Sixteen of the 19 youth (84%) had minimal involvement with their birth fathers and had few, if any, positive male role models. Of these 16 youth, five fathers (31%) were deceased, and one was in prison.

- Eleven (58%) of the 19 homicide victims had involvement with the juvenile justice system. Three were involved as the result of committing violent crimes. Four were in the custody of DYRS at the time of their deaths.

- Ten (53%) of the youth received special education services.

- Ten (53%) had at least one parent or caregiver who abused drugs (crack cocaine, marijuana, or PCP).

- Seven (37%) spent time in out-of-home care, including psychiatric hospitalization or residential treatment.

- Seven (37%) had histories of substance abuse, and at least one was suspected of drug trafficking.

- Seven (37%) were struggling with multiple challenges, such as substance abuse, involvement in the juvenile justice system, and psychiatric issues.

[4] OCME 2010 Annual Report, p. 11. These data only include youth up to age 19. No corresponding data are yet available for 2011.
[5] This number may be low since the CFRU rarely receives the final results of investigations into homicides.

Infant Fatalities, 2010-11

In 2010, 11 children under age 2 who were known to CFSA died, the same number as youth age 17 and older. In 2011, nine infants died. Seven (78%) were males. *The total number (n=20) of fatalities for the <24 month age category encompasses 2 years (see Table 7, Appendix*). The oldest child in this group was 6 months old. Three infants died on the day of their births.

Sixteen (80%) infants died of natural causes in 2010-2011. Of these, seven (44%) were known to have been premature births. At least two of these infants died from birth defects unrelated to prematurity. One death was ruled as "abuse homicide" and another was accidental. The OCME could not determine the manner of death for two of the infants. Families of two (20%) infants had active cases with CFSA at the time of death and families of five (50%) had closed cases. Three (30%) families had closed referrals. As noted earlier in the document, four (36%) of the deaths in 2010 were related to an unsafe sleep environment. While still troubling, this is only half the number of fatalities linked to unsafe sleeping the previous year. The cause of death for three (75%) of these infants was "sudden unexplained infant death" which was specifically associated with incidents of bed sharing[6] (vs. soft bedding).
No table of contents entries found. The cause of death for the remaining infant was hypoxic brain injury due to positional asphyxia. None of the infant deaths in 2011 were attributed or related to unsafe sleeping conditions.[7]

Although nine mothers and four fathers of the 20 infants had a known history of substance abuse, including cocaine, marijuana, PCP and alcohol, there were only two infant fatalities where parental substance abuse may have been a contributing factor. In one case, the mother tested positive for marijuana at the time of the child's birth. The child, however, tested negative, and had no known medical problems at the time of discharge from the hospital. She died of unknown causes three weeks later. In the other, the baby's father, who was lying in bed next to the infant while intoxicated, rolled over onto the child.

Every infant fatality is a tragedy that all of us want to prevent if at all possible. The District has seen improvements in the child mortality rate in recent years. For example, the 2010 rate was at an historic low of 8 per 1,000 live births, down from 9.9 per 1,000 just a year earlier.[8] This overall trend may have a bearing on the smaller percentage of infant deaths in this report. Nevertheless the city's infant mortality rate is still higher than the national average of 6.14 per 1,000 live births.[9]

Medically Fragile Children and Youth

Some children and youth involved with the child welfare system have serious, chronic, medical conditions. Medical fragility makes these youngsters vulnerable to fatalities by natural causes, and CFSA intervention generally focuses on ensuring they are safe and receiving consistent and appropriate medical care.

In 2010 and 2011, nine children and youth (15% of all fatalities of children known to CFSA) from age 0 (died on the day of birth) to 21 died from a serious medical condition. Among conditions ultimately responsible for the natural deaths of these children and youth were muscular dystrophy, pancreatic and

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[6] The OCME Report for 2010 only cites one death for "Sudden Unexplained Infant Death – Associated with Bed-Sharing or Soft Bedding." http://ocme.dc.gov/sites/default/files/dc/sites/ocme/publication/attachments/2010%20OCME%20AnnualRpt.pdf p. 41.
[7] As we discussed in our previous report, *Child Fatalities-2009*, CPS social workers routinely speak with parents of young children about the dangers of bedsharing and the importance of safe sleeping arrangements.
[8] DC Department of Health, *2010 Infant mortality Rate for the District of Columbia*
http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=23327&year=2012&file=file.aspx%2frelease%2f23327%2f2010%2520Infant%2520Mortality%2520FINAL%2520(05%252014%25202012_MAPS_edited)%2520.pdf
[9] www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

liver cancers, cerebral palsy, and pneumonia. Four of these fatalities were infants born with such serious medical issues that they never left the hospital.

For the first time, two young people who died of natural causes were severely obese. Both were males, and their stories are similar in many regards. Both weighed more than 400 pounds and died at age 19. Both had substance abuse issues and behavior problems, and both actively resisted participating in services intended to address these challenges. Each youth was raised by a caregiver who did not succeed in helping him to manage his weight. In one case, the caregiver actively sabotaged the youth's diet regimen. Both received extensive services and repeated interventions from CFSA and medical providers. Nevertheless, both youths persisted in behaviors that ultimately led to their deaths.

Abuse Homicides, 2010-11

Fatalities that occur at the hands of a parent, legal guardian, or another person responsible for the child's care at the time of death are classified as "abuse homicides." These incidents make up a small portion of the total number of fatalities known to CFSA, yet they are of the greatest concern because our mission is to protect children from abuse and neglect.

While no District child died from abuse in 2011, four children and youth known to CFSA died from abuse in 2010.

- Two victims were male and two were female ranging in age from 4 months to 17 years. Although the youngest children are generally considered to be at highest risk of death from abuse, three of the victims in 2010 were teens.

- CFSA was not actively involved with any of the four families at the time of the fatality. For two of the families, we had investigated reports of abuse and neglect in the past and determined the allegations were unfounded. We did not open cases with those families. We did open cases with two of the families and served them at home (no child removal to foster care). At the time of the fatalities, one of these cases had been closed for 16 months and the other for four years.

- All the perpetrators were biological parents of the victim children, three fathers and one mother. One of the fathers was a teen.

- Adult mental health issues, domestic violence, and sexual abuse were factors in one or more of these deaths.

Victim #1: Mother Set Fire to Apartment, Killing All Her Children

CFSA Involvement: One investigation in 2006, unfounded

A 14-year-old male, his three siblings, and their mother were found dead in his family's New York apartment as the result of a fire, determined to be caused by arson.[10] The mother and 2-year-old child died of smoke inhalation and burns. Police initially suspected that the youth started the blaze as he had a history of challenging behaviors, including a recent school suspension for assault and setting fires in the neighborhood. However, evidence uncovered during the investigation later clearly implicated the mother.

While living in DC in 2006, CFSA had investigated the family for neglect. At that time, the youth was the only child in the mother's care. The two middle children were living with relatives in the mother's country of origin, and the youngest child was not yet born. We determined the allegation was unfounded.

[10] We have not included the three siblings (ages 10, 7, and 2) in our fatality data because only the oldest child was involved in the investigation we conducted in 2006.

The family had support through their church and the child's school.

Victim #2: Teen Father Charged with Murdering Infant Son

CFSA Involvement: Alleged perpetrator was the subject of an in-home case, January-June 2006

A 4-month-old boy died from multiple blunt force injuries to his head, a lacerated liver, and fractured ribs (some acute and some healing). The child lived with his mother but was on a weekend visit with his 17-year-old father, who was in the care of his paternal aunt (also his guardian). The father noted that the infant appeared unconscious and had fluid coming out of his nose and transported him to the hospital. The infant reportedly had health complications since birth, including trouble breathing. Doctors had been concerned that the infant may have had a cyst between his vocal cords, a condition that required regular appointments at Children's National Medical Center and Howard University Hospital. During the investigation, the father provided inconsistent information, and police later arrested and charged him with felony murder and cruelty to children. The infant's mother, 16, had only this one child with the father and had never been involved with CFSA.

The teen father had experienced a number of challenges in his young life. His mother had a history of drug use and died in 2000 of a terminal illness. The teen father had a diagnosis of the same terminal illness, along with ADHD and mental retardation. His older brother and maternal grandmother, who had assumed care of him, died in a car accident in 2005. His father was not involved in his life, and his maternal aunt, who also had a history of substance abuse, became his legal guardian.

CFSA's most recent involvement with the family was a neglect investigation in 2006, regarding the teen father, then 13. Although we determined the neglect allegation was unfounded, we did find him at risk given the maternal grandmother's poor health and the maternal aunt's drug use. CFSA provided services, and the young teen participated in therapy. We referred the maternal aunt for a substance abuse assessment, and the family moved in with a maternal uncle who helped care for the young teen. The family was stable at the time of case closure, and CFSA had connected them to their local Healthy Families/Thriving Communities Collaborative for community-based support.

Victim #3: Father Stabbed Teen Daughter to Death

CFSA Involvement: Two investigations in 2010, with findings of "inconclusive" and "unfounded"

In November 2010, the body of a 17-year-old female was found with 17 stab wounds. The youth reportedly lived with her father and went to school in the District during the week but stayed with her mother in Maryland on weekends. The mother reported her daughter missing, and police discovered her body a day later. Police arrested and charged the father with first-degree murder after finding evidence that he had sexually assaulted the girl before her death and sent text messages from her phone to make it appear as if someone else had killed her. He eventually pled guilty to premeditated murder while armed. In 2011, the court sentenced him to 40 years in prison.

CFSA received two reports, one alleging neglect and the other physical abuse, within a week in May, 2010. Maryland CPS also received a referral regarding the mother's household. Based on interviews with the teen girl, her mother, and school personnel (who spoke highly of the father and of his involvement in his daughter's education), we did not substantiate the allegation of physical abuse and determined the neglect allegation to be inconclusive. Although the CPS social worker made contact with the father, no interview of him was completed due to the father's resistance and refusal to meet with the CPS social worker. As there was no reason to believe that the youth was in imminent danger, CPS had no legal grounds to force the father to allow access. However, neither the mother nor the school voiced any concerns regarding the girl's care at her father's home. Most important, we interviewed the girl at school (away from either parent), and she denied any abuse or neglect and had no bruises, contrary to the report made to the hotline. Although the identity of the reporter was not disclosed to her, she suspected she know who had made the report and claimed she had not spoken to him recently

CFSA closed the investigation after significant internal discussion and review, including approval by the CPS Administrator who determined we had insufficient grounds to keep it open. The youth, who was an older teen and articulate in speaking for herself, had given no indication that she was unsafe.

Victim #4: Father Shot Teen Daughter

CFSA Involvement: Two CPS reports, 2004 and 2007; in-home case in 2009

A father shot and killed his daughter, 13, during a domestic violence incident. On the day of her death, she was home with five of her six siblings when her father arrived with a gun. The mother was away from the home with her adult son, who received a call from the father saying they needed to come home immediately. By the time Mother and her son arrived at home, Father had shot the 13-year-old. Before fleeing by car, Father shot Mother and her 10-year-old son, both of whom survived. Police later caught the father, and a grand jury indicted him for 24 charges, including first-degree premeditated murder while armed, kidnapping while armed, and assault with intent to kill while armed. Reports are that the father's attorney has filed for an insanity defense.

The father had a history of mental illness, substance abuse, and criminal activity, including domestic violence. He had drug convictions as a young adult and was convicted of kidnapping and second degree sexual assault in Maryland in 2005. He was sentenced to prison and was on parole during parts of CFSA's involvement with the family dating back to 2004.

CFSA's first two investigations in 2004 and 2007, were for allegations of neglect and physical abuse involving the mother. We determined both were unfounded and referred the family to the local Healthy Families/Thriving Communities Collaborative for services.

In 2009, CFSA investigated a report that the father had neglected and physically abused the decedent and her two older sisters during an incident which resulted in the father's arrested for domestic violence. He was not living at home at the time but arrived there intoxicated. He got into an altercation with the mother, during which one of the teen daughters (not the decedent) tried to intervene. CFSA substantiated neglect by the father as a result of his substance use and opened an in-home case to support the mother. During the case, the social worker helped the family to get mental health services for the decedent's sibling, who went into a psychiatric hospital shortly after the incident with her father.

A month after we opened our in-home case in 2009, police arrested the father again after he threatened the mother. The social worker helped Mother access and use local services for victims of domestic violence, including Crime Victims Services for obtaining a civil protection order (CPO). The social worker also gave the mother contact information to explore options for moving with her Section 8 voucher. At the time of case closure, the family was stable. The father had an ankle bracelet that Maryland was monitoring. CFSA closed the case in 2009.

Accidents, 2010-11

Six children died by accident in 2010 and 2011: two as pedestrians hit by cars, one as a passenger in a car, one in a fire, and one as a drowning victim. One accident stemmed from bed sharing. Two of these fatalities highlight the importance of not leaving young children alone.

- A 4-year-old boy sustained lethal injuries when a car hit him. He chased a ball into the street between two parked cars. His mother was on her way back from a neighborhood store when the accident occurred. Although CFSA was not involved with the family at the time of the accident, CFSA had an open case between 2008 and 2009 which stemmed from concerns about adequate supervision.

- Two brothers, ages 4 and 9 and 13, were left in the care of their 13-year-old sister at night in an apartment building that caught fire. Although the older children were able to leave the apartment by the stairway, the 4-year-old was found unconscious. He died at a local hospital from smoke inhalation. The mother had left the children to run to a local store and had reportedly been gone less than five minutes when the fire broke out. The family was linked to Strong Families and other community providers and declined additional assistance or services. The mother had a long history of CFSA involvement, but her most recent case had closed a year earlier.

The fatality related to co-sleeping involved a 7-week-old male who suffocated while sharing a bed with his father. The father had picked up the crying infant from the crib in the middle of the night, held him in his arms, and lay down in the bed. The mother had stepped out for a moment and returned to find that the father had rolled over and on to the infant. The father later disclosed that he had been drinking that evening. His blood alcohol content was .143.[11]

Suicide, 2010-11

Suicide is the rarest cause of death for children and youth known to CFSA. The Medical Examiner ruled one fatality in 2010 a suicide. The decedent, a youth age 16, hanged himself. He had been born with several rare and severe physical deformities and had gone through a number of surgeries to address his chronic medical needs.

The child was in and out of foster care for the first six years of his life due to his mother's incarceration and his father's instability. The father eventually gained custody and the child remained in his care until age 9, when the father left him with the mother and maternal grandmother. CFSA opened an in-home case to offer supportive services to the family. The social worker particularly encouraged the family to get counseling for the youth for issues related to abandonment by his father and feelings of isolation from his peers as a result of his chronic medical needs. The maternal grandmother, who was the primary caregiver, felt counseling conflicted with her religious beliefs. When we closed the case in February of 2008, the child was involved with a therapist at school regarding peer relationships.

Geographic Location of Fatalities

Of the 59 children and youth who had previous CFSA contact and who died during the 2010-2011, most were residents of Wards 5, 6, 7, and 8. Most of the children, youth, and families CFSA serves come from these wards, and data related to fatalities in this review are consistent with historical trends for fatalities in these geographic locations.

Maps in Figures B through E give details about locations of non-homicide and homicide fatalities for 2010 and for 2011.

[11] OCME determined that the death was accidental. CFSA nevertheless substantiated the father for "neglect-substance abuse impacts parenting" as a result of a determination that his alcohol use limited his ability to provide a safe environment for his child. An in-home case was opened for supportive services as there were surviving children living in the home.

Figure B

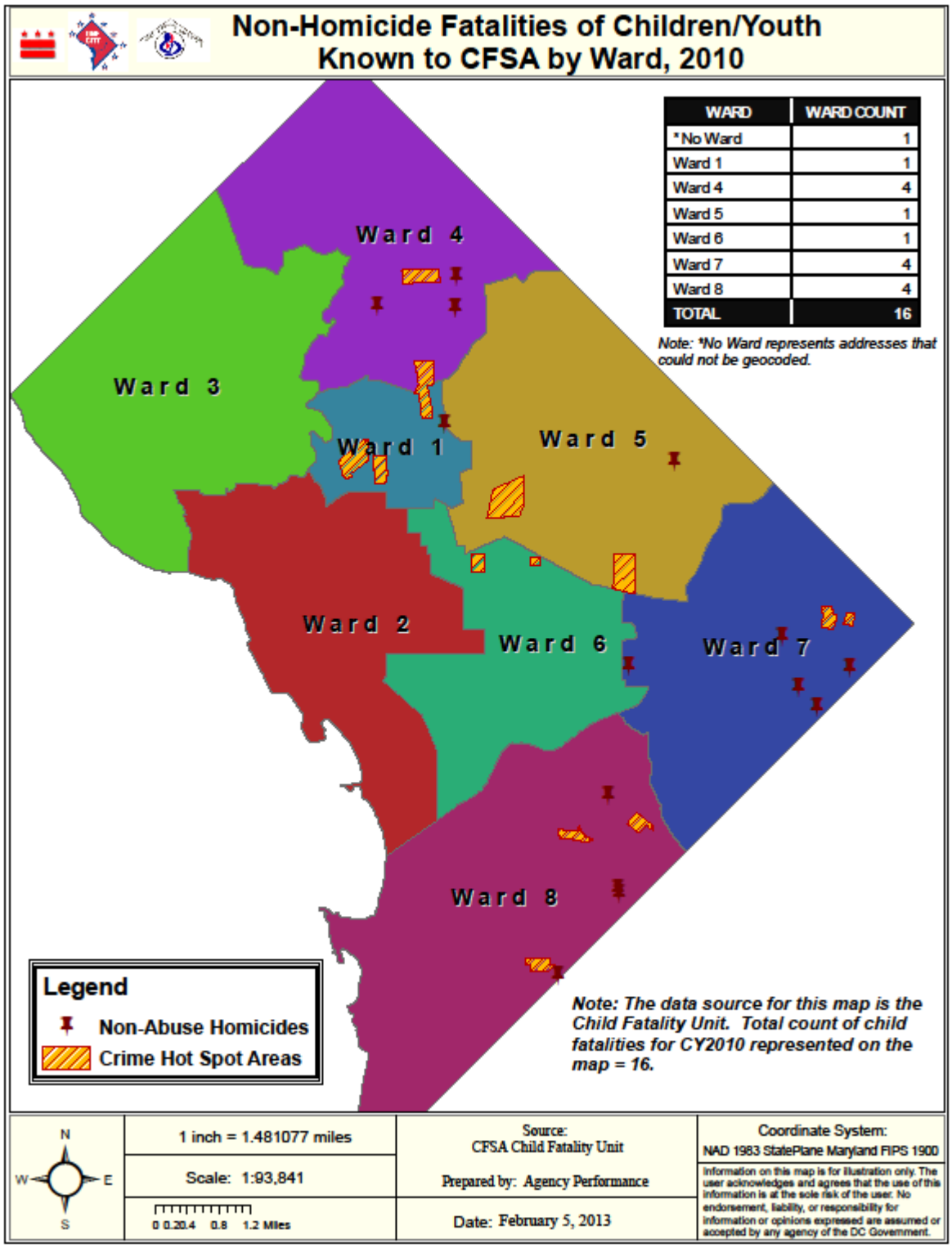

Non-Homicide Fatalities of Children/Youth
Known to CFSA by Ward, 2010
WARD | WARD COUNT
*No Ward | 1
Ward 1 | 1
Ward 4 | 4
Ward 5 | 1
Ward 6 | 1
Ward 7 | 4
Ward 8 | 4
TOTAL | 16
Note: *No Ward represents addresses that could not be geocoded.
Ward 3
Ward 4
Ward 1
Ward 5
Ward 2
Ward 6
Ward 7
Ward 8
Legend
Non-Abuse Homicides
Crime Hot Spot Areas
Note: The data source for this map is the Child Fatality Unit. Total count of child fatalities for CY2010 represented on the map = 16.
N
W
E
S
1 inch = 1.481077 miles
Scale: 1:93,841
0 0.20.4 0.8 1.2 Miles
Source:
CFSA Child Fatality Unit
Prepared by: Agency Performance
Date: February 5, 2013
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
Information on this map is for illustration only. The user acknowledges and agrees that the use of this information is at the sole risk of the user. No endorsement, liability, or responsibility for information or opinions expressed are assumed or accepted by any agency of the DC Government.

Figure C

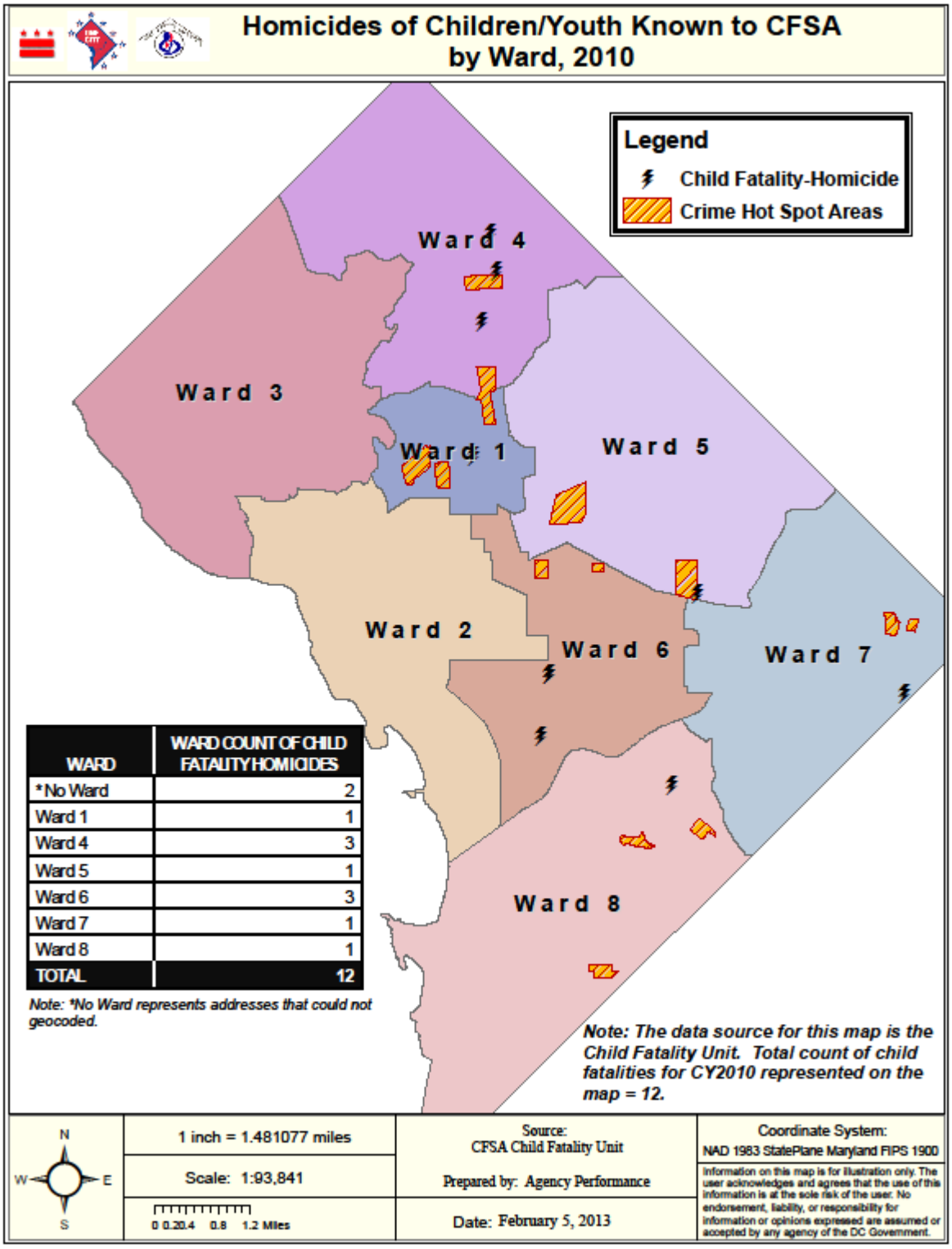

Homicides of Children/Youth Known to CFSA
by Ward, 2010
Legend
Child Fatality-Homicide
Crime Hot Spot Areas
Ward 4
Ward 3
Ward 1
Ward 5
Ward 2
Ward 6
Ward 7
Ward 8
WARD
WARD COUNT OF CHILD FATALITY HOMICIDES
*No Ward 2
Ward 1 1
Ward 4 3
Ward 5 1
Ward 6 3
Ward 7 1
Ward 8 1
TOTAL 12
Note: *No Ward represents addresses that could not geocoded.
Note: The data source for this map is the Child Fatality Unit. Total count of child fatalities for CY2010 represented on the map = 12.
N
W
E
S
1 inch = 1.481077 miles
Scale: 1:93,841
0 0.20.4 0.8 1.2 Miles
Source:
CFSA Child Fatality Unit
Prepared by: Agency Performance
Date: February 5, 2013
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
Information on this map is for illustration only. The user acknowledges and agrees that the use of this information is at the sole risk of the user. No endorsement, liability, or responsibility for information or opinions expressed are assumed or accepted by any agency of the DC Government.

Figure D

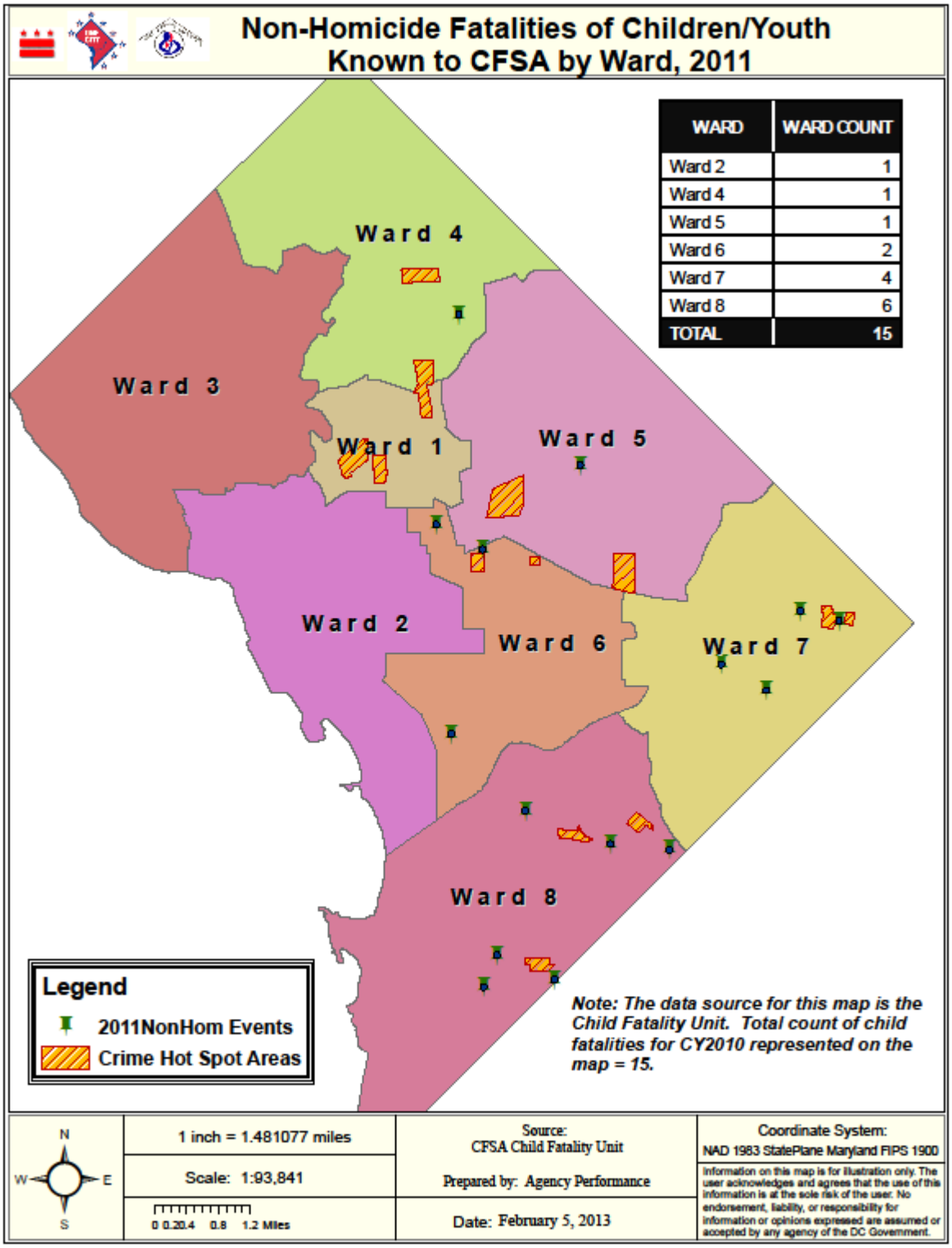
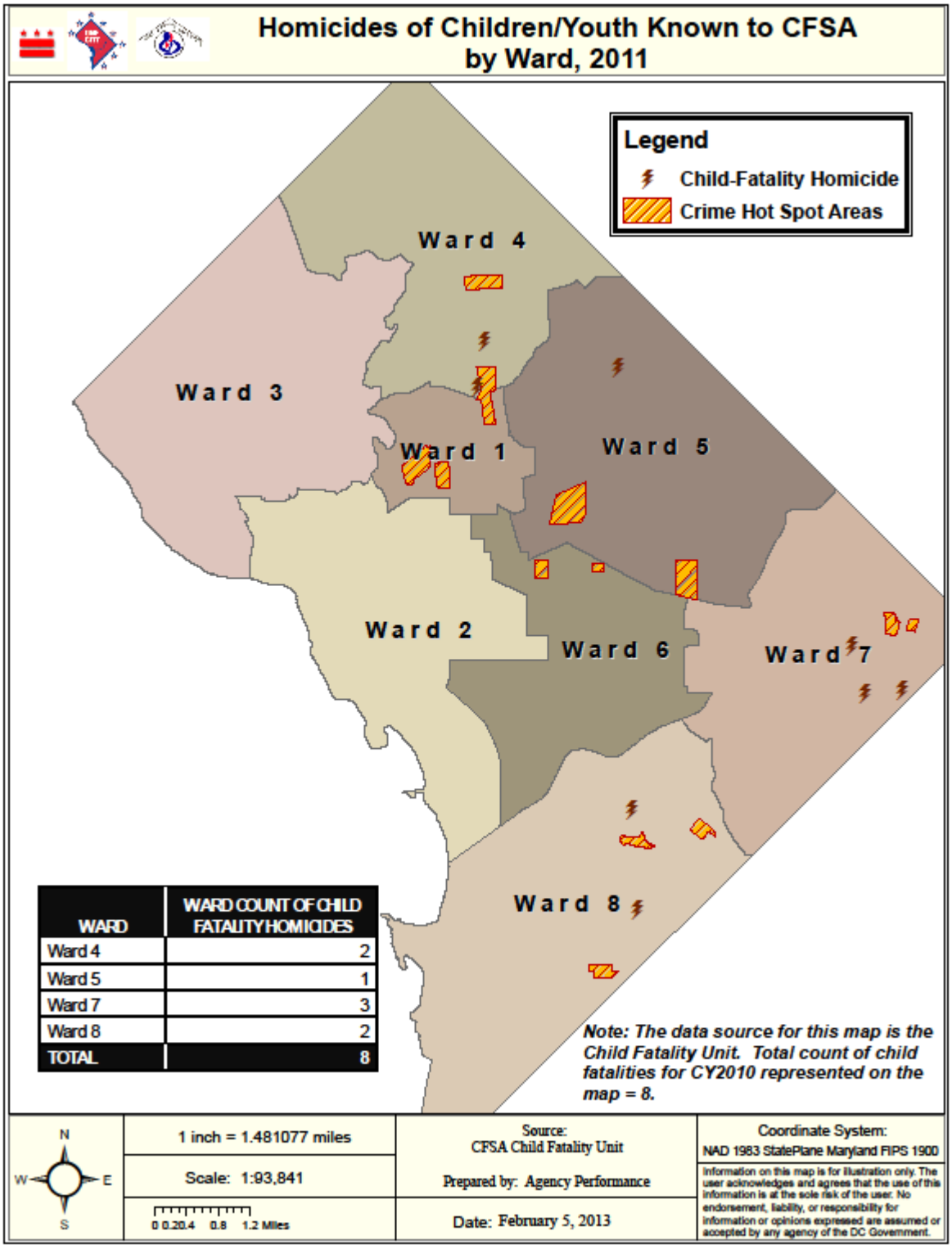

Non-Homicide Fatalities of Children/Youth
Known to CFSA by Ward, 2011
WARD
WARD COUNT
Ward 2 1
Ward 4 1
Ward 5 1
Ward 6 2
Ward 7 4
Ward 8 6
TOTAL 15
Ward 4
Ward 3
Ward 1
Ward 5
Ward 2
Ward 6
Ward 7
Ward 8
Legend
2011NonHom Events
Crime Hot Spot Areas
Note: The data source for this map is the Child Fatality Unit. Total count of child fatalities for CY2010 represented on the map = 15.
N
W
E
S
1 inch = 1.481077 miles
Scale: 1:93,841
0 0.20.4 0.8 1.2 Miles
Source:
CFSA Child Fatality Unit
Prepared by: Agency Performance
Date: February 5, 2013
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
Information on this map is for illustration only. The user acknowledges and agrees that the use of this information is at the sole risk of the user. No endorsement, liability, or responsibility for information or opinions expressed are assumed or accepted by any agency of the DC Government.

Figure E


Homicides of Children/Youth Known to CFSA
by Ward, 2011
Legend
Child-Fatality Homicide
Crime Hot Spot Areas
Ward 4
Ward 3
Ward 1
Ward 5
Ward 2
Ward 6
Ward 7
Ward 8
WARD
WARD COUNT OF CHILD FATALITY HOMICIDES
Ward 4 2
Ward 5 1
Ward 7 3
Ward 8 2
TOTAL 8
Note: The data source for this map is the Child Fatality Unit. Total count of child fatalities for CY2010 represented on the map = 8.
N
W
E
S
1 inch = 1.481077 miles
Scale: 1:93,841
0 0.20.4 0.8 1.2 Miles
Source:
CFSA Child Fatality Unit
Prepared by: Agency Performance
Date: February 5, 2013
Coordinate System:
NAD 1983 StatePlane Maryland FIPS 1900
Information on this map is for illustration only. The user acknowledges and agrees that the use of this information is at the sole risk of the user. No endorsement, liability, or responsibility for information or opinions expressed are assumed or accepted by any agency of the DC Government.

Recommendations and Actions

Individual reviews of a child fatality require a thorough examination of all facts, details, and nuances related to the child's death. The resulting recommendations, along with the subsequent actions taken to implement those recommendations, are all part of CFSA's commitment to protect children and to reduce the number of preventable deaths.

As noted in the introduction to this report, CFSA conducts an internal review of all deaths where we had contact with a child or the child's family within the current or four past years. These reviews have two levels:

- First Level Review: A Child Fatality Critical Event Meeting that occurs immediately following notification of a death; participants include a multidisciplinary group of CFSA personnel.

- Second Level Review: A monthly Internal Child Fatality Review Meeting that includes representatives from CFSA and other organizations.

In addition, the District's Child Fatality Review Committee (DC CFRC) under the Office of the Chief Medical Examiner (OCME) reviews all child deaths in the District to identify broad systemic issues that influence these fatalities. Generally, recommendations flow from every level of review. In 2010 and 2011, however, DC CFRC produced no specific recommendations regarding CFSA practice, policy, or training. As a result, this section lists selected recommendations from internal sources only.

First Level Review:
Selected Recommendations from Child Fatality Review Unit (CFRU) Reports Following Critical Event Meetings

Each fatality report that CFRU staff complete discusses areas of strength in case practice as well as findings and issues regarding CFSA's involvement with the family. Some of these findings are very case-specific and cannot be generalized, and some address practice issues from years ago that have since improved. Others highlight areas where CFSA needs to take specific corrective action. For example, in 2008, CFRU identified several findings (listed below) that CFSA has addressed, while others continue to be raised as areas for enhancement in case practice. These include:

Breadth and depth of assessment of family situations and risk factors are inconsistent.

While CFRU has seen many examples of quality assessment over the past two years, all social workers need to ensure an exacting and thorough attention to family social history. It is particularly important that social workers rely upon their training and, if needed, consultation with supervisors to ensure they have asked all pertinent questions regarding risk. This includes exploring not only the specific allegation reported to CFSA but also going beyond the allegation to probe nuances and potential areas of concern that may have emerged after the social worker has actually met with the family.

Gaps in FACES.NET documentation limit a complete picture of investigations.

CFRU has taken steps to fill in the gaps in information by talking with supervisors, social workers, family support workers, nurse care managers, and others who are currently or have previously worked with the family. Even still, if the social worker is no longer with the Agency or there has been a lapse in time since the social worker was involved with the family, he or she may not be able to offer additional information. This limits the capacity of FACES.NET to provide a comprehensive picture. The system is intended to be the social work "paper trail" that anyone with legitimate access can follow to understand an investigation

or case so proper and accurate data entry is essential. This is especially critical if and when another social worker or supervisor needs to assume responsibility for the investigation or case. It is imperative for social workers to provide thorough documentation.

Examples of documentation gaps include several instances in which a social worker identified a need or concern while working with the family but the available documentation did not reflect whether one or more of the following occurred:

- A referral was made to connect the family to appropriate services.
- Confirmation was documented that the family participated in the services.
- Confirmation existed that the social worker assessed whether the services were actually helping the family.

This led to statements in CFRU reports such as, "The investigator stated that the risk level for the family was high and recommended referrals for domestic violence services, parenting, and individual and family counseling. However, there was no documentation that referrals were ever made for the family." It is often unclear whether these gaps indicate a failure to act or a failure to document. Either way, CFSA holds dear the motto: "If it isn't in FACES, it didn't happen."

Failure to contact important sources of Information or to verify information

In some instances, investigators or social workers appeared to have neglected to contact important collateral sources of information about children, youth or families. An example includes social worker verification of a caregiver's statements regarding a mental health diagnosis, medication management, and treatments. Again, it is unclear whether these gaps indicate a failure to act or a failure to document.

Changes in standards of practice render assessment problematic.

An issue that has arisen repeatedly over the years has been the difficulty for CFRU to accurately identify standards of practice, at the time under review. Although ultimately very positive, there is still rapid, ongoing child welfare reform within CFSA that has spurred a nearly continuous evolution of practice standards. At times, formal policies and other written guidance for staff have not kept pace with all changes and updates. As a result, it is often difficult to determine whether a social worker was complying with all policies, procedures, and practices in force at a given point in the past and the period now under review in the present.

Nevertheless CFRU has witnessed a distinct increase in instances where written policy is available and clear to social workers, and evidence where existing practice is preventing certain errors or oversights.

Second-Level Review: *Selected Recommendations from the CFSA Internal Child Fatality Review Committee*

In 2010 and 2011, CFSA's internal Child Fatality Review Committee reviewed 53 of the 59 deaths of children know to CFSA that took place in 2010-11. CFRU analyzed the recommendations and identified themes indicating areas where CFSA needs to focus more attention.

1. **Recommendation:** CFRU staff will confer with the CFSA's Foster Care Resources administration regarding a private agency's practice of documenting supervision.
   Context: A finding made in the original review of the 2010-2011 reports indicated that there was no documentation that supervisory consultation had occurred on a case managed by a private agency. During the review, the private agency supervisor stated that supervision had occurred and

was documented in their agency logs, but not in FACES.NET. The private agency staff requested that this be clarified, as they were not aware of the requirement that supervisory consultations be documented in FACES.NET.
Action: CFSA officials met with private agency leadership and clarified the expectations that all supervision be documented in FACES.NET.

2. **Recommendation:** CFSA should determine the circumstances under which staff should research criminal histories of clients.
   Context: Jurisdictions around the country have differing practices regarding the practice of checking public websites to determine whether adult clients have a criminal history that might affect the safety of children, family members, or CFSA social work staff. In some jurisdictions this is considered part of the normal process of assessing and gathering information on clients. In others it is only used in specific cases or in response to certain types of allegations. CFSA has no written guidance for staff in this area. In the case in question, a social worker was unaware of the violent history of a client with whom she worked for several months.
   Action: At the time of this writing CFSA has not yet made a determination on this issue. Concerns have been raised about the relevance of this information and the possibility that CFSA staff would further stigmatize individuals already overrepresented in the criminal justice system.

3. **Recommendation**: When there are multiple numbers for the same individual, CFSA should identify ways to merge or link client identification numbers that will not result in any lost information.
   Context: The case in question involved a mother with five different client numbers in the FACES.NET database. Duplicate numbers increase the likelihood that important client information will be lost.
   Action: This is currently one of three main projects being addressed by CFSA's Child Information System Administration (CISA). The project is currently scheduled to be completed in February 2013.

4. **Recommendation**: Increased efforts should be made to document supervisory consultation on investigations in FACES.NET. This documentation should include any recommendations made to social workers. In addition, supervisors should ensure that recommendations made during consultation are completed prior to approving investigations for closure.
   Context: FACES.NET documentation frequently does not indicate whethere critical decisions made during the course of a case or investigation are made with the approval or consultation of the social worker's supervisor.
   Action: The quality and thoroughness of CPS documentation has increased over the last several years, due both to additional IPOM training and coaching of supervisors as well as to internal Agency requirements.

Conclusion

In memory of every child and youth known to CFSA who died before reaching adulthood and to all those young people in need of protection in our city:

All of us at CFSA continuously strive to improve our skills and abilities as investigators, social workers, managers, and administrators and to build a stronger and more effective safety net to protect the children, youth, and families of the District.

Appendix

Table 7: Manner of Death and Demographics for 59 Children Who Died in 2010-2011 and Who Had Contact with CFSA at any Point in the Preceding Four Years							
*Manner of death:**	***Natural Cause***	***Non-abuse Homicide***	***Abuse Homicide***	***Accident***	***Suicide***	***Undetermined***	***Total***
AGE							
<24 months	16	0	1	1	0	2	**20**
2-6 years	2	0	0	3	0	0	**5**
7-12 years	0	0	0	0	0	0	**0**
13-16 years	2	4	2	1	1	0	**10**
17+ years	7	15	1	1	0	0	**24**
GENDER							
Male	13	18	2	4	0	1	**38**
Female	13	1	2	2	1	2	**15**
STATUS WITH CFSA AT TIME OF DEATH							
Closed case	7	7	2	3	1	1	**21**
Active case	6	6	0	0	0	0	**12**
Closed investigation, no case opened	10	6	2	3	0	1	**22**
Active investigation	4	0	0	0	0	0	**4**
PLACEMENT LOCATION AT TIME OF DEATH							
Not applicable: case closed	17	13	4	6	1	2	**43**
In home	8	2	2	0	0	2	**10**
Out-of-home placement	2	4	0	0	0	0	**6**
Total	**27(46%)**	**19 (32%)**	**4 (7%)**	**6 (10%)**	**1(2%)**	**2 (3%)**	**59**

** Information from Medical Examiner or CFRC as of October, 2012. Final numbers provided by CFRC may differ from numbers reported earlier based on preliminary data.*
*** Medical Examiner issued an autopsy report but was unable to determine cause of death.*